Making the Case for Leadership Roles in Partnerships for Policy, Systems and Environmental Change Approaches to Healthy Communities

by

Amy Paulson, BS, BSBA

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Second Reader Signature/printed name

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Abstract

The Centers for Disease Control and Prevention (CDC) states that chronic diseases are a leading cause of death (70%) in the US each year and have a significant impact on quality of life, and disability. Obesity, heart disease, diabetes and cancer are primarily caused by lack of physical activity, poor nutrition, and tobacco; all modifiable health risk factors. A variety of reports heralded the need to focus on chronic disease; including reports from the Surgeon General's Office, Institute of Medicine (IOM); and the first-ever White House Task Force on Childhood Obesity. All these reports consistently stated that chronic disease and its associated factors were issues of national importance that require immediate action. These documents outline the need for leadership through broad-based partnerships for preventive public health practice to remedy this problem.

A policy, systems and environmental (PSE) change approach to healthy communities includes changes such as: improving the built environment to promote walkability, policies to improve nutrition and physical activity, and legislation to ban smoking. These issues required individual actions and partnership building, as well as the thoughtful foresight of leaders to implement PSE to impact population health. Policy, systems and environmental changes to develop healthy communities were identified as potentially far reaching and sustainable approaches to impact population health by the IOM and CDC. The CDC and other public health entities championed local level partnerships to mobilize communities and leaders to establish initiatives to implement PSE approaches. These approaches, however, require specific actions, leadership and political will within communities, and the appropriate level of players within the partnership to enact meaningful change. Leaders with decision-making influence have been called to action to be involved in the process of creating change through partnerships. However,

little guidance is given on the roles these leaders should play in the partnership process. This paper will 1) review the evidence-based and best practice approaches related to the roles of leaders with decision-making influence in PSE partnership approaches; and2) provide recommendations for successful leader involvement in these partnerships. Furthermore, the paper will investigate the following questions: What does the research tell us about the roles of leaders in successful PSE change partnerships approaches for healthy communities? Does involvement in these partnerships by leaders with decision making influence increase the effectiveness of PSE approaches? What are the documented results of effective leadership within partnerships that may be applied to healthy community partnerships?

Introduction

The Center for Disease Control and Prevention's (CDC) Healthy Communities Program focuses on mobilizing communities and their leaders to address the important issue of chronic disease. Chronic disease is the leading cause of death in the US, accounting for 7 out of every 10 deaths in the US. Obesity and related conditions of diabetes, stroke, heart disease, and tobacco-use related cancer and respiratory diseases, have a significant impact on health, quality of life, and disability (CDC National Center for Chronic Disease Prevention and Health Promotion, 2009; CDC, 2011a). Lack of physical activity, poor nutrition, tobacco use and alcohol use, the four most common causes of chronic disease, are considered to be modifiable which would impact both prevention and management of chronic disease (CDC, 2011a).The burden of chronic disease is significant, with almost fifty percent (50%) of people in the US. having at least one chronic illness that consumes seventy-five percent (75%) of healthcare spending (CDC, 2011a).These conditions also adversely affect racial and ethnic minorities which contributes to our growing health disparity and inequity gap (CDC, 2011a; CDC National Center for Chronic Disease Prevention and Health Promotion, 2009). The urgency of finding solutions to these chronic diseases is significant, as the health and economic burden is high and increasing rapidly.

A variety of reports heralded the need to focus on chronic disease and related risk factors as issues of national importance that require immediate action. Reports from the Surgeon General's Office, Institute of Medicine (IOM), and the first-ever White House Task Force on Childhood Obesity (2010) outline the need for leadership action through broad-based partnerships for preventive public health practice to remedy this problem. While these documents detail the best practices and evidence-based approaches for technical aspects of the community policy, systems and environmental (PSE) change intervention, they do not address

what roles these leaders play in the partnership processes that lead to effective PSE change. Thus, we must look to research on leadership within health care institutions, public health, coalitions and partnerships to identify the best methods to support effective leadership for healthy communities.

Understanding how or if leadership plays a role in creating healthy communities is critical to developing more successful approaches. Evidence-based and best practice approaches for community health partnerships and coalitions are a growing area of knowledge. Research on grassroots and community initiatives can expand our understanding of how leaders should be involved in partnerships, the roles they play, and what makes them effective change agents in PSE approaches (Butterfoss, 2007; Granner & Sharpe, 2004). The solution to the complex problems of chronic disease may fundamentally lie in the ability of our leaders to champion promising, best practice and evidenced-based approaches, such as those as outlined in CDC's 2011 guidance document, *Strive to Implement High Impact Policies* (CDC Healthy Communities Program, 2011). However, our leaders must understand the leadership processes and actions behind these suggested policies to ensure success.

This paper will identify promising, evidence-based and expert opinion roles for leaders with decision-making influence in PSE change partnerships related to tobacco use, physical activity, and nutrition. It also will identify barriers and provide recommendations for successful leader involvement in these partnerships. The following questions will be investigated:

- What does the research tell us about the roles of leaders in successful PSE change partnerships approaches for healthy communities?
- Does involvement in these partnerships by leaders with decision making influence increase the effectiveness of PSE approaches?

- What defines effective leadership and what are the documented results of effective leadership within partnerships that may be applied to healthy community partnerships?

Methods

This exploration included a comprehensive review of available resources related to chronic disease, healthy communities, partnerships, coalitions, leadership frameworks, and national models. Indexes included PubMed, Google Scholar, and Google searches using keywords such as “Champions”, “Chronic Disease”, “Coalition/Partnership Leadership”, “Collaborative Leadership”, “Decision-maker and partnership”, “Decision-maker and policy”, “Healthy Communities”, “Leadership”, Leadership and Health Communities”, “Leadership Competencies”, “Leadership Models”, “Leadership Roles”, “Meta-leadership”, “Policy Champion”, “Policy-maker and partnerships”, “Policy, Systems, and Environmental Change”, “Public Health Leadership Competencies”, “Public Health Leadership”, and “Roles, Leaders, Policy”. PubMed was searched to identify relevant peer-reviewed articles. Articles of interest were used to identify additional citations. Google Scholar was used to identify potential sources, particularly for leadership, that may not be indexed within PubMed. Google searches identified lay literature, fact sheets, action guides, and other relevant community-based documents that lent support to the exploration of the issue. Several books also were included in the literature review, including basic texts on public health, leadership, IOM reports, and coalitions. Specific websites of interest were searched to identify materials, information, and tools that supported the exploration. The CDC website was searched extensively for relevant information and was a key source of information on the Healthy Communities Program. Similar reviews of other websites, such as Healthy People 2020, were made to identify additional information. In total, 131 sources were specifically consulted as relevant in developing this paper and the authors’ understanding

of the issues, although not all are cited directly. Additional sources were reviewed in brief and discarded as not specifically relevant, but were not recorded.

The author's involvement in the Action Communities for Health Innovation and Environmental Change (ACHIEVE) program allowed a further exploration via a series of in-person and web conference calls with national program staff and representatives from other ACHIEVE communities that provided insight for this topic. ACHIEVE is funded by the CDC's Healthy Communities program. Additionally, lessons learned from the author's participation in two ACHIEVE Action Institutes, evaluating site visit reports for the 2009 National Association of Chronic Disease Directors (NACDD) ACHIEVE Communities Cohort, and serving as the lead coach in the Portsmouth, Virginia ACHIEVE initiative, lent insight and direction to the search for supporting works and observations of best and promising practices, evidenced-based approaches, as well as potential gaps and barriers.

Defining leaders. In the literature on leadership and partnerships, the influence of specific community members within the greater community is limited. For instance, a mayor, a pastor, and a concerned citizen all may have leadership positions either within a partnership or within the greater context of the community and be referred to as leaders. They may have influence within their own sectors, but differing degrees of influence on policies, systems and environments and different access to community resources. One of the hallmarks of healthy communities' approaches is the recommendation for involvement of leaders with formal positions, usually in government. The literature does not differentiate the roles of these leaders from others in the partnership nor does it define leadership in this manner. Historical documents identify a role for such leaders, but do not provide evidence-based or best practice guidance on their roles within these partnerships. Many partnerships and coalitions define and measure

leadership differently, which creates challenges for referring to leadership uniformly (Zakocs & Edwards, 2006). For the purpose of this exploration, *community leaders* or *leaders with influence* shall be considered those with formal and significant influence on larger scale PSE change approaches, such as a mayor or city official. *Leaders*, however, may be those with influence within any community sector or at any level within the community or partnership. For instance, a leader may be a coalition member who provides leadership within the partnership through a formal role such as chairperson or an informal role as a member, but may or may not hold a position of influence outside the partnership.

Literature Review

This section will explore the literature and available resources, both peer-reviewed and community-originated, to: 1) provide best practice and evidence-based approaches for the roles of leaders in successful partnerships for healthy communities; 2) identify credible and evidence-based approach to create health outcomes change; 3) overview key catalyst activities and their recommendations; 4) identify applicable theories and frameworks; and 5) answer the key questions of this paper.

Leadership Roles: Evidence-based and Best Practices. This review will focus on identifying credible and evidence-based information on leadership roles. The evidence for roles and effectiveness of leaders in partnerships indicate that information from systematic reviews of research literature that generally provide guidelines, summaries of evidence, and recommendations from government agencies, professional organizations and convening expert panels, as well as meta analyses and systematic reviews of peer-reviewed literature should be included (Lamar Soutter Library University of Massachusetts Medical School, 2008). Brownson, et. al (2009) advises using the best available peer-reviewed evidence (both qualitative and

quantitative) as a key approach to choosing quality public health interventions. However, community based interventions can be challenging to measure in terms of impact and effectiveness because they occur within the community context and may be difficult to separate out from other influential factors (El Ansari, Phillips, & Hammick, 2001; El Ansari & Weiss, 2006; Roussos & Fawcett, 2000).

Best practices, which rely on the experiences and evaluation of programs, interventions and policies, also may be used to inform decision making although they provide a weaker level of evaluation evidence as compared to evidence-based practices and systematic reviews. The strongest evidence should be considered first, as identified in Figure 1. However, in cases where it is not available or strong, systematic reviews, expert or consensus opinion and best practices should be considered and help build a foundation towards acquiring evidence-based practices (Brownson, Fielding, & Maylahn, 2009; Lamar Soutter Library University of Massachusetts Medical School, 2008). The need to make decisions and address an issue of significant concern often exists before robust scientific evidence or sound best practices emerge. In these cases, the best available information or promising practices should be applied while continued work to create an evidence-base and identify best practices is underway; such is the case with some aspects of the healthy communities' movement (Anderson et al., 2005; CDC Healthy Communities Program, 2011).

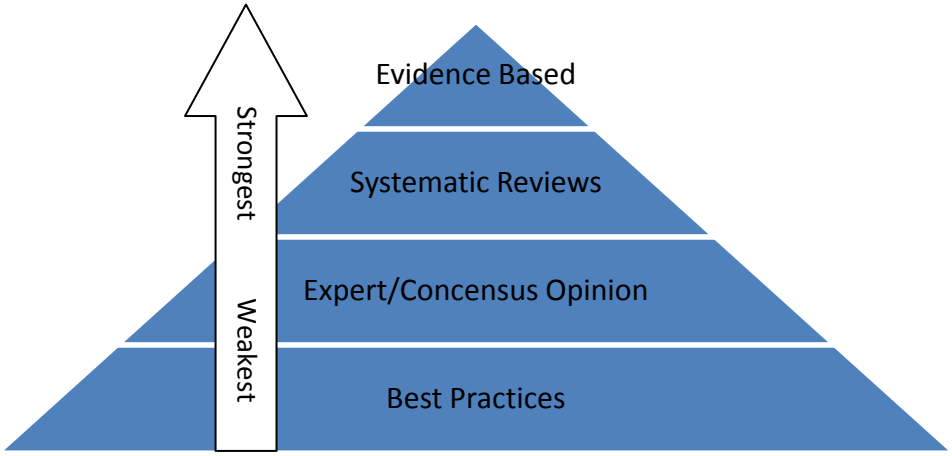

Figure 1: Hierarchy of Evidence-based Practices (Lamar Soutter Library University of Massachusetts Medical School, 2008)

Healthy Communities Leadership Framework. To support implementing recommendations for change for healthy communities, CDC's Healthy Communities Program has engaged communities and mobilized national networks to move toward action. National Networks include a variety of partners: US State and Territorial Health Departments Collaborative for Chronic Diseases, National Association of Chronic Disease Directors (NACDD), National Association of County and City Health Officials (NACCHO), National Recreation and Parks Association (NRPA), Society for Public Health Education (SOPHE), and Y-USA. The Program also has funded 306 communities and 50 state health departments to implement PSE through a shared leadership, partnership model and provided appropriate tools, strategies and training as well. Programs include: Strategic Alliance for Health (SAH) communities, **A**ction **C**ommunities for **H**ealth, **I**nnovation, and **E**n**V**ironmental Chang**E** (ACHIEVE), Pioneering Healthier Communities (PHC), Racial and Ethnic Approaches to Community Health Across the United States (REACH US) communities, Steps Communities, and Communities Putting Prevention to Work (CCPW). Generally, these initiatives focus on reducing tobacco smoke exposure; eliminating health disparities; improving nutrition and physical activity environments, risk factors, policies, and associated health conditions; and,

increasing access to care (CDC Healthy Communities Program, 2011). This paper focuses on these partnerships and identifies where "healthy community" or "PSE change" approaches are referenced.

Leadership Roles: Roots of Change. What does the research tell us about the roles of leaders in recent, successful PSE change partnerships approaches for healthy communities? Between 1970 and 2010, a series of reports and initiatives recommended involving leaders as a critical part of a comprehensive public health approach to chronic disease utilizing evidence based and best practice sources (See Table 1).These reports serve to provide systematic review and identification of issues and evidence to move forward implementation of evidence-based and best practice solutions for chronic disease and public health issues of significance.

These reports address PSE best practices and evidence-based approaches and identify a need for leaders in public and private sectors to recognize the relationship between health and the environment. They recommend the need for a focused coordinated leadership effort, but generally do not address the specific role of leaders (Campaign for Tobacco Free Kids, 2010; CDC, 2000; Committee on Prevention of Obesity in Children and Youth, 2005; Institute of Medicine, 2004; Institute of Medicine, 2007; Khan et al., 2009; Public Health Leadership Institute, 2009; U.S. Department of Health and Human Services, 2001; U.S. Department of Health, Education, And Welfare, 1979; US Department of Health and Human Services, 2000; White House Task Force on Childhood Obesity, 2010). For instance, the Surgeon General's report in 1979 recommended leader involvement and provided examples specific to policy change approaches for public health, but did not identify specific roles or best practices for the involvement of leaders (U.S. Department of Health, Education, And Welfare, 1979). The lack of direction for leaders gave rise to the creation of the Public Health Leadership Institute in 1990 to

improve understanding of leadership issues, roles, skills and competencies (such as using data to make decisions, working in partnerships) and to provide support for good leadership in public health (Public Health Leadership Institute, 2009).

Table 1:
Timeline: Key Reports Addressing Public Health Leadership for Policy, Systems & Environmental Change

Year	Catalyst
1979	Healthy People: Surgeon General's Report on Health Promotion and Disease Prevention
1990	Healthy People 2000
1990	Public Health Leadership Institute founded
2000	Healthy People 2010
2001	Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity
2002	Congressional mandates creates the IOM task force for preventing childhood obesity
2004	Child Nutrition Act and the Richard B. Russell National School Lunch Act were reauthorized
2005	IOM report Preventing Childhood Obesity: Health in the Balance
2007	Progress in Preventing Childhood Obesity: How Do We Measure Up?
2009	CDC's Morbidity and Mortality Weekly Report (MMWR) Recommended Community Strategies and Measurements to Prevent Obesity
2009	Family Smoking Prevention and Tobacco Control Act
2010	President's Task Force on Childhood Obesity
2010	First Lady's Let's Move Initiative launched
2010	Healthy People 2020

Leadership Roles: Individual Engagement and Actions. What does the research tell us about the roles of leaders in successful PSE change partnerships approaches for healthy communities in terms of individual leadership actions and involvement? The 2001 *Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity* addressed specific recommendations for actions related to engage leaders to accomplish change, such as:

- Informing leaders about healthy communities;
- Using best practice programs;
- Raising policy-makers awareness of healthy community approaches; and,
- Utilizing a framework that included communication, actions, and research and evaluation actions (U.S. Department of Health and Human Services, 2001).

The *2001 Surgeon General's Report* recommended leadership actions after engagement, such as forming community coalitions, championing policy, systems and environmental and social norms changes. This report also encourages leaders from across sectors and levels to create dialogue and action through public-private partnerships. However, no guidance is provided in this document on best practices or evidence based approaches for leaders in regard to these roles and actions, either individually or through building partnerships to promote change (U.S. Department of Health and Human Services, 2001). More recent sources, which include systematic reviews of the literature as well as case studies and evaluation reports, identify basic roles and actions for leaders that provide some guidance on leader roles, including:

- Taking on voluntary leadership roles;
- Serving as champions to carry forward objectives;
- Employing leadership actions through their work, such as changing policies or practices under their control;
- Working strategically in political environments where they may have expertise to gain support for initiatives, exert personal or formal political influence, and gain insight into the political climate impacting the issue;
- Framing policies and action appropriately to gain support; and,
- Utilizing influence to allocate staff or financial resources

(Ploeg et al., 2010; Public Health Leadership Institute, 2009; Satterlund, Cassady, Treiber, & Lemp, 2011; Thompson, Estabrooks, & Degner, 2006; U.S. Department of Health and Human Services, 2001; Zakocs, Tiwari, Vehige, & DeJong, 2008.

One study identified overlapping and inconsistent use of leadership role terms across the literature, sought to identify primary roles of leaders, and put forth the following universal definitions:

- Opinion leader - uses formal and social influence to persuade
- Facilitator – leads groups and collaborative processes effectively
- Champions – uses internal influence to put forth new ideas, generally is involved in all stages of the change process
- Linking agent – provides connections to collaborations, resources and people through position or influence
- Change agent – uses expert status and relationships to prompt change usually intended to be sustained independently from the leader

(Thompson et al., 2006)

Although these terms can be defined, the study noted that these terms are used inconsistently and interchangeably throughout the literature which may make linking any specific role to successful program outcomes difficult. This study identifies potential roles of leaders in a change effort which may be useful to advocates and leaders in determining the role of a leader in a group, despite what terminology may be applied (Thompson et al., 2006).

However, to be successful in these types of roles, the Public Health Leadership Institute report, *Developing Leaders, Building Networks: An Evaluation of the National Public Health Leadership Institute – 1991-2006,* identified a need for individual leader development, such as:

- Greater understanding, skills and valuing of certain approaches in public health and leadership;
- Validation of the importance of public health leadership;
- Understanding and validation of their self as a leader; and,
- Confidence, courage responsibility and the motivation to lead (Public Health Leadership Institute, 2009).

These recommendations for individual leadership skill development fit well with those for engaging leaders promoted by the *2001 Surgeon General's Report.* Utilizing this information could inform what activities are needed to engage leaders, what skill development may be beneficial, and what roles will prepare them to secure their participation in a leader role to move forward change. This leaves us now with the issue of whether their participation in partnerships in these various roles actually increases the effectiveness of the program or approach.

Leadership Roles: Involvement Impacts. Does involvement in these partnerships by leaders with decision making influence increase the effectiveness of PSE approaches? The Community Guide, as well as CDC's *Strive to Implement High Impact Policies,* provides evidence base approaches and best practices for PSE change interventions that impact health outcomes. These sources were reviewed for support for leader roles and impact on PSE change effectiveness. Both sources propose that leaders have a role, but do not outline the leadership role or provide a related evidence base or best practices for leadership involvement (CDC Healthy Communities Program, 2011; The Task Force on Community Preventive Services, 2010). The Institute of Medicine's 2005 report, *Preventing Childhood Obesity: Health in the Balance,* recommends that leaders serve as change agents for these interventions and use their influence to create synergy and collaboration to create the political will for change to take place (Institute of Medicine, 2004;

Koplan, Liverman, Kraak, & Committee on Prevention of Obesity in Children and Youth, 2005). The *2005 IOM Report* provided action steps for interventions and directives for leaders (i.e., create a farmer's market, adopt a complete streets policy), although it did not identify evidence based approaches for accomplishing these steps or the specific roles of leaders related to these steps. Nevertheless, these action steps for PSE fit well with the public health leadership competencies (shown below in Table 2) and provide direction for identifying best practices and evidence-based approaches from other areas of the peer reviewed literature (Council on Linkages Between Academia and Public Health Practice, 2011; Committee on Prevention of Obesity in Children and Youth, 2005).

TABLE 2. Examples of Immediate Steps for Leaders & Public Health Competencies

Sector	*Recommended Steps for Immediate Action by IOM*	*PH Skills & Competencies*
Federal government	• Establish an interdepartmental task force and coordinate federal actions	Community Dimensions
	• Develop nutrition standards for foods and beverages sold in schools	Policy Development
	• Fund state-based nutrition and physical-activity grants with strong evaluation components	Financial Planning
	• Develop guidelines regarding advertising and marketing to children and youth by convening a national conference	Policy & Program Development
	• Expand funding for prevention intervention research, experimental behavioral research, and community based population research; strengthen support for	Basic PH Science
Industry and media	• Develop healthier food and beverage product and packaging innovations	Leadership & Systems
	• Expand consumer nutrition information	Communication
	• Provide clear and consistent media messages	Communication
State and local governments	• Expand and promote opportunities for physical activity in the community through changes to ordinances, capital improvement programs, and other planning practices	Policy & Program Development
	• Work with communities to support partnerships and networks that expand the availability of and access to healthful foods	Community Dimensions
Health-care	• Routinely track BMI in children and youth and offer appropriate counseling and guidance to children and	Analytic & Assessment

professionals	their families	
Community and nonprofit organizations	• Provide opportunities for healthful eating and physical organizations activity in existing and new community programs, particularly for high-risk populations	Cultural Competency
State and local education	• Improve the nutritional quality of foods and beverages authorities and schools served and sold in schools and as part of school-related activities	Policy & Program Development
	• Increase opportunities for frequent, more intensive and engaging physical activity during and after school	Policy & Program Development
	• Implement school-based interventions to reduce children's screen time	Policy & Program Development
	• Develop, implement, and evaluate innovative pilot programs for both staffing and teaching about wellness, healthful eating, and physical activity	Policy & Program Development
Parents and families	• Engage in and promote more healthful dietary intakes and active lifestyles (e.g., increased physical activity, reduced television and other screen time, more healthful dietary behaviors)	Policy & Program Development
Sources: Excerpt from Committee on Prevention of Obesity in Children and Youth, 2005, p 19 & Council on Linkages Between Academia and Public Health Practice, 2011)		

In 2007, the IOM issued a follow up report, *Progress in Preventing Childhood Obesity: How Do We Measure Up?* This report focused on evaluation actions taken across sectors, as recommended in the 2005 report, to establish if the PSE leadership approach was working. This report provided an increasing base of support for a PSE approach to healthy communities focused on outcomes. This outcomes focus, however, led to published literature that reported on what was done, rather than the effective leadership processes that were behind the actions (Institute of Medicine, 2007; CDC, 2011b; Guide to Community Preventive Services, 2010; United States Department of Agriculture Food and Nutrition Service). The majority of articles on PSE approaches reviewed mention leadership as a factor for success, but do not address how and

why the roles of leaders makes the PSE change approach successful (Alexander, Hearld, & Mittler, 2011; Bors et al., 2009; CDC, 2011b; Guide to Community Preventive Services, 2010; Clark, 2000; Clark et al., 2010; Cousins, Langer, Rhew, & Thomas, 2011; Cradock et al., 2011;; Craig, Felix, Walker, & Phillips, 2010; Dobson & Gilroy, 2009; Easton, 2009; El Ansari, Oskrochi, & Phillips, 2009a; Fawcett, Schultz, Watson-Thompson, Fox, & Bremby, 2010; Institute of Medicine, 2004; Jaime & Lock, 2009; Kraft & Brown, 2009; Mishkovsky, 2010; Pittman, 2010; Rockeymoore, 2009; Roussos & Fawcett, 2000a; Story & Orleans, 2006; The Community Guide to Preventive Services Task Force, 2010; United States Department of Agriculture Food and Nutrition Service, 2004).

The impact of the underlying approaches to PSE change needs to be supported through evidence-based and best practices in order to advise leaders on effective roles. This appears to be a significant gap in the literature and evidence-based research. Consequently, we must look towards evidence based and best practice research conducted in other sectors that focuses more broadly on effective leadership and partnerships (Yancey, 2009).

Leadership Traits. What defines effective leadership and what are the documented results of effective leadership within partnerships that may be applied to healthy community partnerships? A systematic review of leadership research in business and health care from 1970-1999 identified that most of the literature consisted of descriptive discussion of leadership traits and characteristics, rather than evidence-based research. Of over six thousand (6,000) articles reviewed, just over four (4%) percent were data-based (Yancey, 2009). A meta-analysis of articles published between 1887 and 2002 looked at the correlation between innate personality traits and transformational and transactional leadership. A weak association was found, although some influence does exist, particularly with the trait of extroversion for which strong

associations with effective leadership were identified (Jaime & Lock, 2009). The literature identifying evidence-based support for determining effective leadership traits and results is somewhat limited.

A meta-analysis by Ilies, et al. (2007), looking at interactions between leaders and members in employment settings, found that increased interaction improved collaborative or "citizenship behaviors" (as the author refers to it) which improve the strength of both individual and organizational relationships. However, the effect was stronger on individual behaviors, suggesting that the leader as a champion who engages individuals in taking action through such partnerships and interactions is valuable to improving partnership performance (Ilies, Nahrgang, & Morgeson, 2007). A study of the skills of 13 coalition project directors representing 8 partnerships identified important skills or traits that included: the leaders' status with the community (whether they were considered an insider or outsider); sharing leadership with others; bridge building skill; expertise; vision; and management style as mediators of leader effectiveness (Vance & Larson, 2002). A leader's actions, skills and style may influence partnership success more than specific personality traits, although some association has been observed (Bono & Judge, 2004).

Effective Leaders and Collaborative Partnerships. Documented results of effective leadership within partnerships may be applied to healthy community partnerships. Roussos and Fawcett (2000) and Ansell and Gash (2008) discuss collaborative governance or partnerships as a means to achieve effective approaches to PSE change. Using systematic review and meta-analysis of a wealth of existing literature, studies, case analysis, and comprehensive evaluations, these studies identified leadership development as the most reported factor in creating effective partnerships and community impacts. Collaborative leadership within partnerships may also

bolster organizational capacity (Alexander, Comfort, Weiner, & Bogue, 2001; Alexander et al., 2011; Alexander et al., 2006; El Ansari, Oskrochi, & Phillips, 2009b; Ilies et al., 2007). Butterfoss (2007) extensively reviewed the literature from studies utilizing meta-analysis, systematic review and published in peer-reviewed journals identifying evidence-based practices related to leadership, partnerships and effective coalition approaches and identified the following factors as the key components of effective coalition action: lead agency or convener role; coalition membership; operations and processes; leadership and staffing, partnership structures; synergy through pooled resources and member engagement; and community assessment, planning and implementation of strategies that result in community change, improved capacity and health and social outcomes.

Kegler (2011) found that group structure and size play key roles in cohesiveness, participation, and leveraging resources. In another study, Kegler, et al, identified other factors that contributed to effectiveness, meaning the partnership's ability to achieve successes in creating change related to community and population level health outcomes. These factors include history of collaboration, community politics and history, norms and values, and demographics and economics (Kegler & Swan, 2011a). Similar factors were identified through a comprehensive multi-site case study which looked critically at these factors across 15 similar partnership sites funded by the Robert Wood Johnson Foundation using standardized measurement tools and comprehensive evaluation of partnership outcomes and processes (Zakocs & Guckenburg, 2007). Across these sources and an extensive search of peer-reviewed articles, the following appear to be critical components identified from a plethora of systematic reviews, case studies, and comprehensive evaluations in the peer-reviewed literature and content experts that can guide leaders to create partnerships that are more likely to lead to PSE change:

- Clear mission and vision (e.g., identification of purpose and focus and ideal outcomes), effective structures (e.g., bylaws and work groups) and processes (e.g., for decision making and handling conflict)
- Community readiness to take ownership of initiative without competition among partners
- Formally defined process for action planning for PSE change, including short and long term actions
- Process for developing and supporting leadership
- Member engagement, including evaluation and stakeholder feedback on progress and processes and task sharing
- Technical assistance and training for implementation and sustainability
- Financial and supportive resources (i.e., grants for the work, paid staff, pooled resources from among members and organizations)
- Outcomes focused, with a balance between planning and taking action for success and an emphasis on evaluation
- Inclusion of diverse stakeholders w/ influence in community
- Process for ongoing and timely communication with membership
- Strong leadership, from both paid staff and/or volunteers, capable of supporting the presence of the other factors

  (Alexander et al., 2001; Ansell & Gash, 2008; Bors et al., 2009; Butterfoss, 2007; Bryman, 2004; Bryson, Crosby, & Stone, 2006; El Ansari, Oskrochi, & Phillips, 2009a; Fawcett et al., 2010;Kegler, Rigler, & Honeycutt, 2010; Kegler & Swan, 2011a; Kegler et al., 2010; Lasker, Weiss, & Miller, 2001; Nowell & Harrison, 2011; Roussos & Fawcett,

2000a; Sharek et al., 2007; Turning Point Collaborative, 2001; Zakocs & Guckenburg, 2007).

Other recommendations reported extensively in the literature support effective leadership as one that provides and creates a collaborative culture with:

- Good communication
- Effective meeting management
- Negotiation; fairness across members
- Effective networking
- Cultural competence
- Capacity to frame the big picture that arises from a shared visioning process
- A climate of trust
- (Alexander et al., 2011; Ansell & Gash, 2008; Butterfoss, 2007; El Ansari, Oskrochi, & Phillips, 2009a; Nowell & Harrison, 2011; Turning Point Collaborative, 2001; Zakocs & Edwards, 2006; Zakocs & Guckenburg, 2007).

Lessons from Expert Advisors. As noted earlier, looking outside the evidence-based literature and best practices may be necessary in situations where promising or emerging practices are being identified (Bryman, 2004). Lessons learned from the Healthy Communities program include creating a diverse leadership team, but also specifically including community leaders, such as local government officials (Anderson et al., 2005). One leader usually does not make change happen in a community, but rather a collection of leaders are able to exert their own influence within specific domains (Figure 4) (*ACHIEVE Healthy Communities: Action Communities for Health Innovation and EnVironmental changE,* 2011; *Group discussions with NACDD, CDC, National Parks &Recreation Association, NACCHO and ACHIEVE communities*

*staff and stakeholders at the 2011 ACHIEVE Action Institute*2011; NACDD Staff, 2011; YMCA of the USA, 2009). What is not known is the extent of the "mix" that should exist between leaders of influence and community members within these partnerships, although other research supports this as essential (Bors et al., 2009; Fawcett et al., 2010). Notably, a shared or collaborative leadership model, which involves sharing of leadership and decision making power to developing plans, allocating resources, and identifying outcomes across multiple leaders, has repeatedly been supported in the literature (Anderson et al., 2005; Alexander, J., et al., 2011; Ansell & Gash, 2008; F. D. Butterfoss, 2007; El Ansari, Oskrochi, & Phillips, 2009a)) Zakocs et al., 2008).

Figure 4. ACHIEVE Communities Leadership Team Model

Source: ACHIEVE Healthy Communities: Action Communities for Health Innovation and EnVironmental changE, 2011

The YMCA-CDC Pioneering Communities program, the first generation of "healthy communities' partnerships", produced a report that explored the leadership aspects of these partnerships and provided clear, concise recommendations specifically for lay leadership. These recommendations are supported by lessons learned from nineteen (19) other successful ACHIEVE communities (*Group discussions with NACDD, CDC, National Parks and Recreation, NACCHO and ACHIEVE communities staff and stakeholders at the 2011 ACHIEVE Action Institute*, 2011; NACDD Staff, 2011). Lessons learned include the following Leading Practices:

1. Start with a shared, compelling vision and spirit of inquiry
2. Adapt to emerging opportunities
3. Borrow from others and build your own
4. Engage cross-boundary leaders who care
5. Serve in multiple roles
6. Use data to guide, not drive, the effort
7. Develop leadership structures that distribute leadership and action

   (NACDD, 2011; YMCA of the USA, 2009, pg. 8)

Finding ways to connect the leaders personally instead of just professionally was instrumental in creating buy-in and responsibility taking. Leaders need to be more than just figure heads. Creating a sense of "team" or shared group valuation of the partnership was important to teams that were considered to be effective. Additionally, finding ways in which the member organizations also benefitted from participating in the partnership increased ownership in the larger group's efforts.

Effective Coalitions and Partnerships. Butterfoss (2007) identifies the Community Organization and Development Model, Framework for Partnerships for Community Development, Framework of Organizational Viability, the Community Coalition Model, and the Collaboration Framework as models that share sharing fundamental, theoretical concepts common to most coalitions and partnerships (Braithwaite, et al, 1989; Butterfoss, 2007; Hogue, 1995; Prestby, 1985). The Community Coalition Action Theory (CCAT) (Figure 5) seems most applicable to healthy community approaches because it recognizes the unique function and structure of community partnerships, as well as community context (Butterfoss & Kegler, 2009). CCAT also considers the "age and stage" of the group, from formation to institutionalization. This theoretical framework may help provide better guidance to healthy communities' partnerships in developing their approach to best match the capacity of the partnership and the needs that these different stages may require (Kegler & Swan, 2011).

In applying evaluative processes using this theory CCAT has been used to predict correlations between leadership and coalition effectiveness. This theory and its application to 20 healthy communities' projects in California found a negative correlation of broad representation to coalition cohesiveness – perhaps suggesting that the most cohesive teams may be smaller, less representative teams (Kegler & Swan, 2011b). Further, shared decision-making was associated with greater satisfaction, participation and pooled resources. This theory identifies the potential implications of diversity and group size, and underscores the value of understanding the roles of leaders within healthy communities' partnerships. A vast evidence-based and best practice literature concerning the effectiveness of coalitions supports this concept and promotes similar theories and findings (Butterfoss, 2007).

Healthy Communities Approaches. Healthy Communities initiatives use shared leadership and partnership models not unlike that of the Mobilizing for Action through Planning and Partnerships (MAPP) model which follows an organizing, visioning, assessment, planning and action process (National Association of Chronic Disease Directors, 2011). However, while MAPP is traditionally carried out with the public health department as the lead entity, CDC's Healthy Communities programs take varied approaches, including lead entities from the Y, coalitions, parks and recreation, and others.

Healthy Communities utilizes a framework for the process of change in communities based on the IOM framework for collaborative public health action by communities (NACCHO, 2010, pg. 186). As this program develops, results will emerge, such as how communities can best develop partnerships for change, useful tools and resources, and increased data on the effectiveness of these partnerships in producing change over time. To date, evaluation has focused on what community interventions work best. Journal articles from CDC's Healthy Communities Program have not focused on the community leadership that is the crux of this paper (IOM Committee on Assuring the Health of the Public in the 21st Century, 2003).

ACHIEVE. The training for and focus of projects, such as ACHIEVE, require a "leadership team" comprised of influential community leaders and citizens. Conversations with key program staff revealed that, while the program provides training on creating partnerships and expects leadership involvement in the initiatives, little is understood about the process by which the most effective community changes are implemented (CDC Healthy Communities Program, 2010). When asked if partnerships with community elected officials were more effective than ones without, or what "mix" of such leaders and members produced the best outcomes, the staff was only able to provide anecdotal support. Yet, a general recommendation persists that elected

and voluntary community leaders, (e.g., mayors or city managers) should serve within these partnerships as these leaders are seen as influential and an important linkage to higher level policy making bodies and capacities although the specific evidence-based best practice role was not identified. Moreover, the types of community PSE change recommended by the CDC Strive document focus on higher level changes to policies, environments and systems which would necessitate the involvement of such leadership for the partnership to be successful (NACDD Staff, 2011). However, in this emerging field, no documented best practices exist for which type of structure and/or leadership roles within the partnership produce the best and most consistent outcomes beyond anecdotal success stories (CDC Healthy Communities Program, 2011). Limited literature is published on the best practices for process and structure related to the roles of community leaders within partnerships focused specifically on PSE change efforts and the Healthy Communities' movement (NACDD, 2011).

At the ACHIEVE Action Institute, some communities discussed having different levels of commitment from leaders and often struggling to "report up" to leaders that have "delegated down" the member's role on the partnership (*ACHIEVE Healthy Communities: Action Communities for Health Innovation and EnVironmental ChangE*, 2011; *Group discussions with NACDD, CDC, NPRA, NACCHO and ACHIEVE communities staff and stakeholders at the 2011 ACHIEVE Action Institute*, 2011; NACDD Staff, 2011). The tendency of leaders to be involved more in spirit than in practice creates a problem of having to take the decisions of the partnership and sell them back to the leaders which are only tangentially involved but who have critical expertise in crafting such decisions and policies to be appealing to the stakeholders involved and might have ensured better success had their investment in the partnership been more substantial. A careful balance of "not too much and not too little" structure was important in creating

dynamic, flexible, and yet productive teams. Role assignment, a facilitative process and a consensus-based decision process were critical as well. Thus, a shared work ethic and shared success among partners and leaders was both a product and an outcome of effective teams.

Discussion & Recommendations

What does the research tell us about the roles of leaders in successful PSE change partnerships approaches for healthy communities? The literature defines effective leadership and supports leadership involvement in partnerships as a way to increase effectiveness of those partnerships. Linking this information with the process of building partnerships and plans for PSE approaches in communities is critical to developing meaningful leadership roles in partnerships. Identification of the roles of leaders, such as is recommended by Thomason and colleagues (2006), is helpful in identifying potential roles of leaders in a partnership. This can help determine how the partnership interacts with community leaders and what role(s) they request the leader take on. However, the literature remains inconsistent in defining and measuring these constraints. Looking across the many recommendations made by the literature, a **leadership involvement pathway** can be developed based on what is currently known and recommended:

1. **Engage the leader** (i.e., using best practices, providing information to raise awareness)
2. **Identify partnership actions that may require leader involvement** (i.e., taking on a leadership role within the partnership, facilitating resource allocation)
3. **Specify what roles they will play to support the partnership in accomplishing actions** (i.e., facilitator, champion)

The leader's role will vary depending on their own resources, leadership style, and position in the community. Better defining their roles through creating an evidence-base for the effectiveness of specific approaches to PSE change is needed. Ongoing training for leaders to build skills should contribute to increased effectiveness.

Does involvement in these partnerships by leaders with decision making influence increase the effectiveness of PSE approaches? Insufficient evidence is available that specifically links the effectiveness of PSE approaches with involvement by leaders in decision making influence at this time. This represents a significant gap in the literature that should be the focus of future studies on healthy communities' partnerships and PSE change approaches. The research focus has been on creating an evidence base for the outcomes of PSE changes (i.e., health impacts or if a policy worked or not), rather than effective leaders roles, processes and structures required to support change. Commonly accessed documents from the IOM, CDC, and The Community Guide provide little support for the role of leaders in partnerships for PSE change beyond the recommendation that "leaders should be involved". While we don't know yet the evidence-based or best practice role for a leader within the partnership to increase effectiveness of PSE approaches, we do know that effective leadership is linked with healthy and productive coalitions and partnerships. Clearly, more research to establish an evidence base specific to healthy communities' partnerships using a PSE change approach is needed. But, in the absence of that information, evidence from similar approaches in the broader leadership and partnership literature may be applied until an evidence-base specific to PSE is established.

What defines effective leadership and what are the documented results of effective leadership within partnerships that may be applied to healthy community partnerships? The broader literature on coalitions and partnerships provides significant evidence for effectiveness

related to building effective leadership in partnerships, such as focusing on good communication, creating shared vision, structures, and meeting management. The need to create partnerships with the structures and processes that continue to engage its leaders and members is critical to success and outcomes.

Based on the findings that are reported in this paper, I recommend the following:

Recommendation 1. Develop and disseminate research that addresses the appropriate partnership roles for community leaders that would most likely increase the effectiveness of the PSE change approach based on current knowledge. Understanding who needs to be involved, what their role specifically should be, and how it helps facilitate successful outcomes is critical to creating more efficient and effective leaders and partnerships.

Recommendation 2. Provide training and resource materials to support leaders in building specific skills needed to support their roles and participation in successful partnerships. Include information on the most effective roles and methods for leaders to employ from the broader research and lay literature. Incorporate this information in commonly accessed resources, such as IOM reports, The Community Guide, and the CDC's recommendations for healthy communities.

Recommendation 3. Provide additional tools to healthy communities' partnerships for assessing their function and leadership roles in order to better understand the impact of these structures on the group's ability to effectively and efficiently implement PSE change in communities.

Recommendation 4. Develop and publish a leadership involvement pathway as a stepwise guide for leaders and partnerships to recommend engagement strategies, identify potential leader actions, and create roles best suited to the leader's resources and influence. Such

a pathway may help to establish a methodology for approaching leadership roles in healthy communities' and PSE change partnerships that may be validated and replicated across communities.

Conclusion

Healthy communities' partnerships are a critical part of creating healthier policies, places and people. The need for leadership involvement in partnerships for PSE change approaches to Healthy Communities is well documented. Creating effective and efficient partnerships for change, appropriately involving leaders, and developing better training and processes are key factors that must be addressed as we continue to grow this important area of work. Creating the research that tells us more about the roles of leaders with decision-making influence in successful partnerships for PSE change approaches for healthy communities should be an area of dedicated focus over the next decade. Understanding how and to what degree to involve leaders with decision making influence in these partnerships to increase the effectiveness of PSE approaches will be increasingly significant as we focus on preventing and managing chronic disease with limited resources. Applying what is known about effective leadership within coalitions and partnerships may help their leaders engage in and sustain effective healthy communities' partnerships. Measuring leadership and partnership action, roles and effectiveness through formal evaluations will ensure that an evidence base is created for recommending roles, processes and structures that are most likely to result in PSE change.

Of note, while the public health shifts to the PSE approach in healthy communities is well documented, the literature is lacking related to linking leadership roles and outcomes. What we don't know is fundamentally how leadership influences what succeeds and what fails. We know what PSE approaches are working to impact health outcomes, but not how many attempts to

promote change may have failed due to lack of leadership or role clarity. Ultimately, while we know much about which PSE approaches work best and that leadership involvement appears critical to their success, much still is to be learned about how, leaders may be most effective at producing the intended outcomes of PSE change for health communities. With chronic disease presenting huge economic and health challenges in our country, understanding what works, how we might best build and engage leaders, and utilize partnerships to effect change is imperative.

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